Behavioral Health Workforce Survey

Winter 2020-2021

In the fall of 2020, the JRI Behavioral Health Workforce Development Workgroup worked with Professor Kelli E. Canada at the University of Missouri - School of Social Work to develop a Qualtrics survey for behavioral healthcare providers across Missouri. The purpose of the survey was to gather information to better understand and address behavioral health workforce barriers and service delivery to Missourians.

Survey participation included service providers from nearly every county in Missouri, with over 215 participants. Questions spanned three main areas: (1) behavioral health workforce retention, (2) adult consumer access to services, and (3) services provided to the adult justice-involved population.

A special thank you to Professor Kelli E. Canada, LCSW, PHD. Dr. Canada is an Associate Professor, the Associate Director of Research, the PhD Program Director, and Director of the Integrative Behavioral Health Clinic at the School of Social Work at the University of Missouri. Dr. Canada was instrumental in developing the Qualtrics survey and compiling the survey data.

Executive Summary

Methodology

A joint letter from the Governor's Office and DMH Director Mark Stringer was sent out to all Missouri Department of Mental Health behavioral health providers providing services to adults requesting their participation in the survey. Participants were told the survey would take approximately 45 minutes to complete and that the results would be de-identified to the extent that no agency or employee names would be collected. Only the counties that the agency serves was retained in order to identify regional trends. The survey was available from mid-September 2020 to mid-January, 2021.

Each agency was asked to complete the survey for each site location that provides mental health and substance use treatment to adult populations. For instance, an agency may have headquarters in one area, but have multiple sites throughout the state. Participants were asked to complete the survey for each site serving the adult population.

Participants were also told that the goal of the study was to gain a broader perspective of what barriers exist in increasing Missourian's access to mental health care and substance use disorder treatment. Aggregate data and a summary report of findings may be made available to leadership at the Department of Mental Health, the Department of Corrections, the Missouri Health Care Workforce Data Project advisory committee, the Missouri Coalition for Community Behavioral Healthcare, and the JRI Executive Oversight Council established by Executive Order 18-08 and recently continued by Executive Order 21-01. Participants were told a summary report may also be made available to participating agencies upon request.

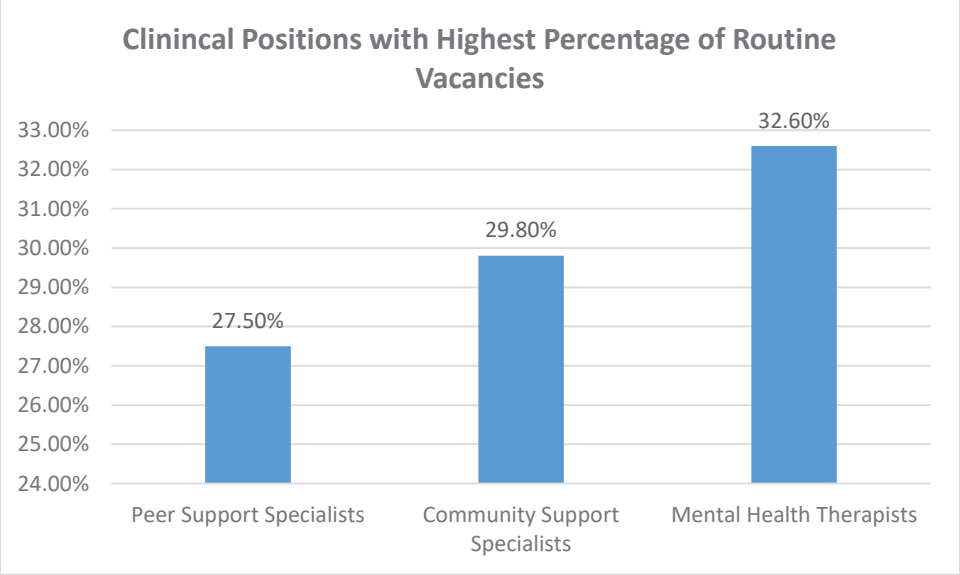
Summary of Results

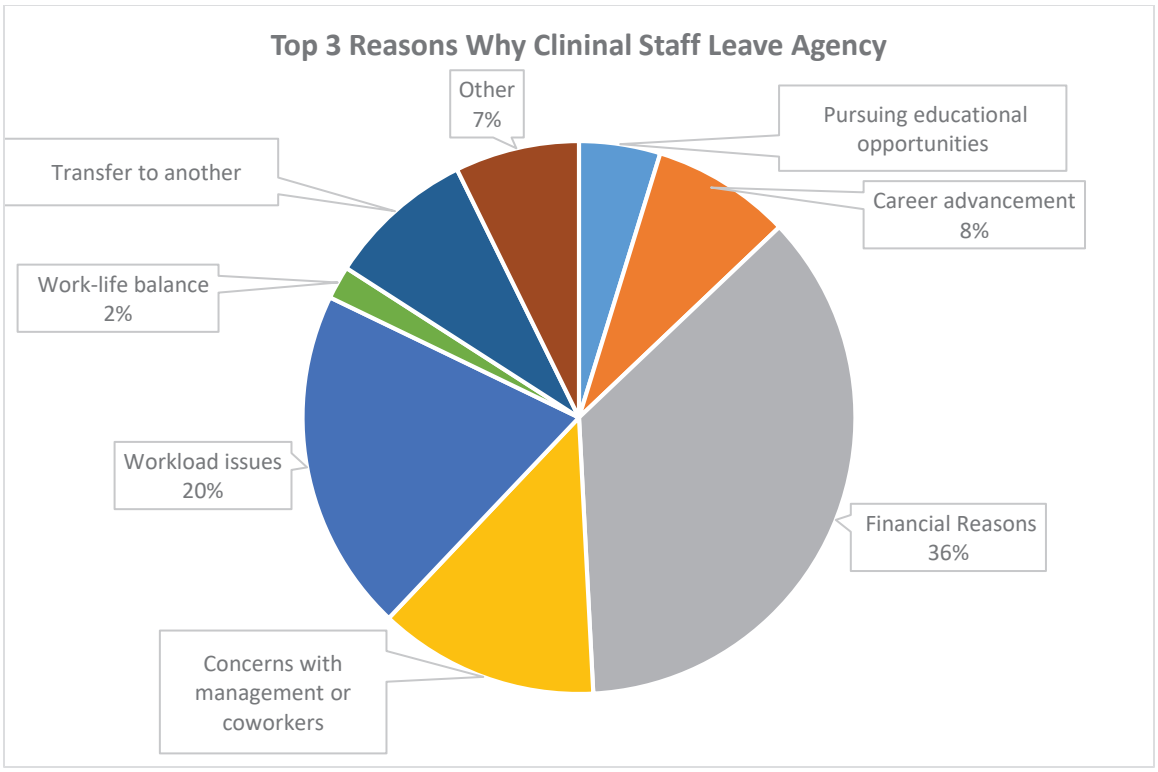
Responses were received from providers who deliver service in nearly every county in Missouri. In total, 215 providers participated in the survey.

Behavioral Health Workforce Retention

- 56.4% of respondents offer peer support for their site full-time, 25.2% offer it part-time, and 14.7% do not offer peer support.
- Greatest amount of time to fill vacancies
    - Peer Support/Community Specialist – Over six months (43.4%)
    - Community Mental Health Counselor – Nine weeks – six months (58.3%)
- Greatest routine vacancies:
    - 32.6% of respondents described Mental Health Therapist vacancies as "routine"
    - 29.8% of respondents described Community Support Specialist vacancies as "routine"
    - 27.5% of respondents described Peer Support Specialist vacancies as "routine"
- Staff currently described as the greatest need:
    - Medication Provider (30.1%)
    - Peer Support Specialist (22.3%)
    - Community Support Specialist (20.2%)

- Most common average caseloads by clinical position: *(of note, caseload goals are typically around 32 cases per day)*
    - Peer specialists – over 20 (about 50% of respondents)
    - Substance use counselors – 41-50 (about 30% of respondents)
    - Community support specialists – 21-30 (about 42% of respondents)
    - Medication prescribers – 1-100 (about 24% of respondents)
    - Mental health clinicians – over 40 (about 55% of respondents)
- Most common typical starting and average salaries for the following full-time positions:
    - Peer support specialist: $25,000-30,000
    - Community support specialist: $30,001-40,000
    - Mental health clinician (LPC, LCSW, QMHP): >$55,000
    - Substance use counselor: $30,001-40,000
- 27.1% of respondents offer employment assistance to consumers outside of typical community support services or specialized programs.
- 20.6% offer specialized support with locating housing for consumers outside of typical support services or specialized programs.

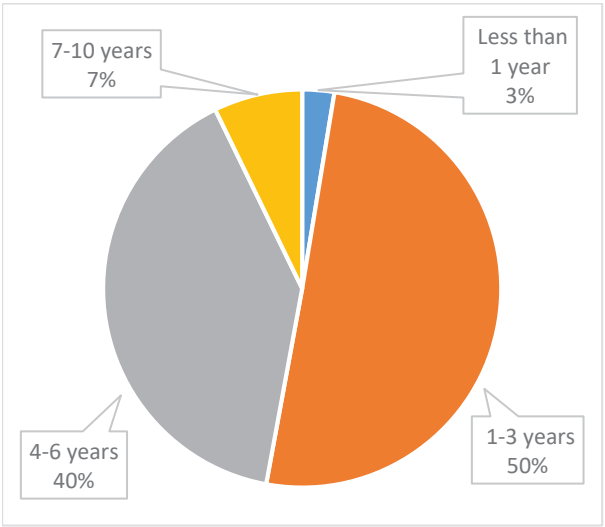




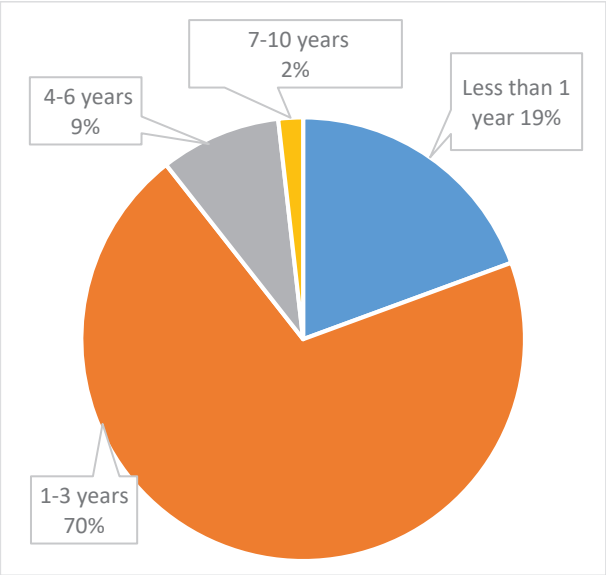
**Other includes: lack of opportunities for growth or development, feeling under-challenged, undervalued or unsupported, lack of training, work-life balance, and burnout.*

Average Tenure for Full-Time Positions

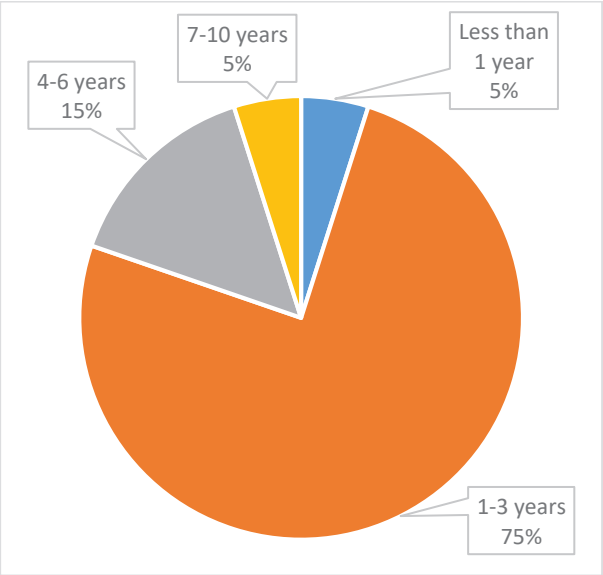
Medication Prescriber



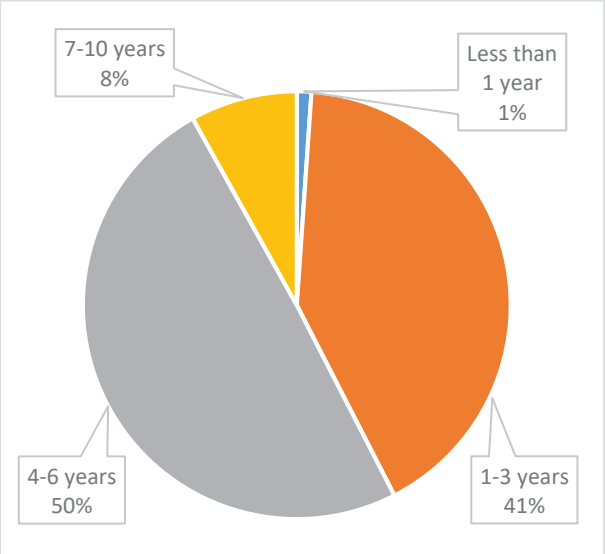
Peer Support Specialists



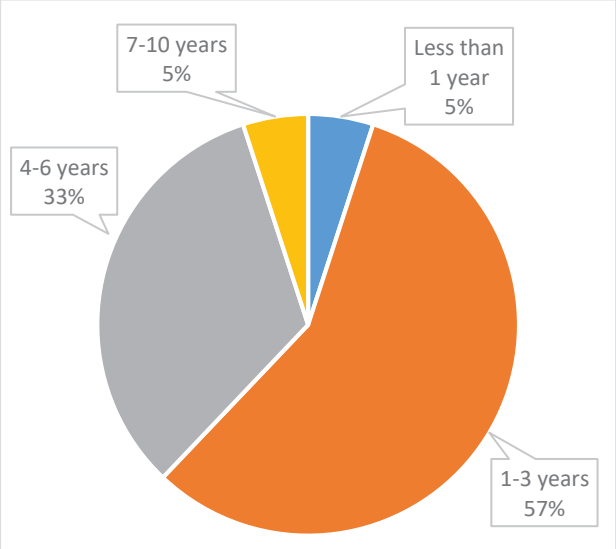
Community Support Specialists



Mental Health Clinicians (LPC, LCSW, QMHP)



Substance Use Counselors



Adult Consumer Access to Services

- Nearly all respondents indicated they are able to serve uninsured clients (91.3%)
- 83.9% of respondents indicated they use a sliding scale fee for uninsured clients
- 43.6% of respondents reported they do *not* believe there are any gaps in services, or adult populations that are underserved or unserved at their site
- The following outpatient services had a wait-list at the time of the survey (in terms of number of agencies with a waitlist):
    - Intake/assessment/triage: 66
    - Community support: 23
    - Mental health counseling: 35
    - Substance use counseling: 19
    - Medication services (MAT, psychiatry): 42
    - Groups/psychosocial rehabilitation: 20
- 36.2% state they do not have a physical location for adult outpatient services in the county of the site's catchment area while only 26.2% offer transportation to treatment offices if a consumer resides out of county (either all the time or under special circumstances).
- Top three platforms utilized for telehealth:
    - Zoom for Healthcare
    - Doxy.me
    - Microsoft Teams

Services Provided to the Adult Justice-Involved Population

(By "justice-involved", the survey refers to adult consumers who are on community supervision by the courts or Probation and Parole, those with pending *criminal* court matters, or those who have experienced involvement in those areas within the past 3 years)

- Over a majority of respondents said they feel either "a great deal" or "a lot" qualified on providing services to justice-involved individuals (64.8% combined)
- 93.7% of respondents indicated they ask consumers about their justice involvement at intake
- The top primary diagnosis presented by justice-involved consumers:
    1. Substance use disorders
    2. Trauma and stressor-related disorders
    3. Depressive disorders, bipolar disorders, and related disorders
- The top secondary diagnosis presented by justice-involved consumers:
    1. Depressive disorders
    2. Substance use and addictive disorders
    3. Anxiety disorders
    4. Trauma and stressor-related disorders
- Most respondents indicated either most or some of their clinical staff would be okay with a *full* caseload of justice-involved consumers (91.8%)
- 55% of respondents said they somewhat agree that clinical staff have a positive opinion of justice-involved consumers

- Over half of respondents indicate they have a good working relationship between their site and the local Probation and Parole office (61%)
- There was a split between respondent opinions on the question of whether the monetary return on investment for justice-involved consumer services is adequate for the time and resources invested in them
- 77.1% of respondents said they feel more Community Mental Health Liaisons (and/or Substance Use Disorder Liaisons) are needed to adequately manage the number of referrals received and the size of the territory covered in their site's catchment area

Behavioral Health Workforce Survey – Winter 2020-2021
Recommendations and Next Steps

The implementation of these recommendations should be in collaboration with related efforts that are already underway. The Workgroup acknowledges there are already a number of existing efforts aimed at supporting the behavioral health workforce in Missouri and maximizing behavioral health outcomes. These recommendations are intended to support those efforts. Wherever possible, the Workgroup seeks to collaborate with those efforts to help maximize their impact in lieu of recreating a new project.

Recommendations:

1. Given recent issues with access to care, develop best practices around alternatives to care if waitlists exist for particular services. Engagement strategies and tools should be shared with provider networks regionally and statewide to ensure individuals have quicker access to care and support.

2. Develop training and continuing education opportunities for behavioral health professionals to attract and retain staff, as well as to improve outcomes for clients. Consider the following:

    - Work to ensure the supportive employment model is integrated into daily practice (including providing supportive employment model support and technical assistance).
    - Increase access to peer support services

3. Promote and encourage the development of provider supports (e.g., provider support networks, system of care, telehealth).
    - Resources might include:
        - MO Psychological Association
        - St. Louis Psychological Association
        - Greater Kansas City Psychological Association
        - National Association of Social Workers – MO Chapter
        - MO Mental Health Counselors Association

4. Promote diversity and inclusion across racial, ethnic, and LGBTQ populations in hiring practices and work towards securing staff members with bilingual skills in order to ensure clients have access to culturally sensitive and appropriate care and services.

5. Encourage cross-sector training, communication, and collaboration among community behavioral health, law enforcement, and corrections professionals in order to better serve justice-involved individuals who receive behavioral health treatment and/or supports.

    - The Sequential Intercept Model could serve as an excellent starting point for this work.

6. Develop and promote virtual medication management options (e.g., telehealth) to assist with lack of access to medication providers, when appropriate.

7. Ensure technology is compatible across systems to facilitate information sharing between providers and those being served.

    - Encourage participation in a system that allows for consistent, effective communication (between providers and for the client) and increased access to care.

8. Create a shared and consistent intake and assessment process to ensure appropriate and effective placement of justice-involved consumers in behavioral health services.

9. Establish mechanisms for behavioral health services to be suspended and restarted without a complete termination of services for individuals entering and exiting jail or prison. Consideration should be given to ensuring funding streams are flexible and to minimize the impact on provider reimbursement and service disruptions as much as possible.

10. Identify and promote best practices for building and fostering good working relationships between providers and local probation/parole offices (e.g., ICTS and systems of care).

Next Steps:

- Future work should focus on identified positions of greatest need and those most difficult to fill. More information is needed to better understand barriers to entry for those positions, as well as challenges to retention.
- If future surveys are conducted, consider exploring whether clinicians are using trauma-informed practices/services or other evidence based practices.
- An area worthy of additional exploration is whether there are gaps in available trauma programming or curriculum(s) that are used by clinical staff across the state. If gaps are identified, best practices could be developed to address them.
- Future work should further explore the average tenure of professionals. Specifically, reasons for leaving positions (e.g., did they leave organization entirely or were they promoted?).

JRI Behavioral Health Workforce Survey Results

Numbers indicate how may survey respondents indicated providing care in the noted county:

ADAIR COUNTY	3	GRUNDY COUNTY	3	PERRY COUNTY	2
ANDREW COUNTY	3	HARRISON COUNTY	3	PETTIS COUNTY	1
ATCHISON COUNTY	1	HENRY COUNTY	1	PHELPS COUNTY	4
AUDRAIN COUNTY	10	HICKORY COUNTY	1	PIKE COUNTY	5
BARRY COUNTY	2	HOLT COUNTY	1	PLATTE COUNTY	4
BARTON COUNTY	7	HOWARD COUNTY	1	POLK COUNTY	10
BATES COUNTY	2	HOWELL COUNTY	2	PULASKI COUNTY	0
BENTON COUNTY	3	IRON COUNTY	2	PUTNAM COUNTY	5
BOLLINGER COUNTY	3	JACKSON COUNTY	29	RALLS COUNTY	3
BOONE COUNTY	10	JASPER COUNTY	10	RANDOLPH COUNTY	6
BUCHANAN COUNTY	3	JEFFERSON COUNTY	5	RAY COUNTY	3
BUTLER COUNTY	7	JOHNSON COUNTY	4	REYNOLDS COUNTY	4
CALDWELL COUNTY	4	KNOX COUNTY	3	RIPLEY COUNTY	5
CALLAWAY COUNTY	4	LACLEDE COUNTY	1	SALINE COUNTY	1
CAMDEN COUNTY	2	LAFAYETTE COUNTY	3	SCHUYLER COUNTY	3
CAPE GIRARDEAU COUNTY	3	LAWRENCE COUNTY	1	SCOTLAND COUNTY	3
CARROLL COUNTY	1	LEWIS COUNTY	7	SCOTT COUNTY	5
CARTER COUNTY	5	LINCOLN COUNTY	6	SHANNON COUNTY	2
CASS COUNTY	6	LINN COUNTY	4	SHELBY COUNTY	3
CEDAR COUNTY	1	LIVINGSTON COUNTY	4	ST. CHARLES COUNTY	12
CHARITON COUNTY	3	MACON COUNTY	4	ST. CLAIR COUNTY	1
CHRISTIAN COUNTY	8	MADISON COUNTY	1	ST. FRANCOIS COUNTY	4
CLARK COUNTY	3	MARIES COUNTY	0	ST. LOUIS CITY	12
CLAY	6	MARION COUNTY	6	ST. LOUIS COUNTY	19
CLINTON COUNTY	1	MCDONALD COUNTY	7	STE. GENEVIEVE COUNTY	2
COLE COUNTY	3	MERCER COUNTY	3	STODDARD COUNTY	6
COOPER COUNTY	2	MILLER COUNTY	2	STONE COUNTY	11
CRAWFORD COUNTY	3	MISSISSIPPI COUNTY	3	SULLIVAN COUNTY	5
DADE COUNTY	1	MONITEAU COUNTY	2	TANEY COUNTY	12
DALLAS COUNTY	9	MONROE COUNTY	3	TEXAS COUNTY	3
DAVIESS COUNTY	3	MONTGOMERY COUNTY	2	VERNON COUNTY	3
DEKALB COUNTY	2	MORGAN COUNTY	2	WARREN COUNTY	5
DENT COUNTY	2	NEW MADRID COUNTY	3	WASHINGTON COUNTY	3
DOUGLAS COUNTY	2	NEWTON COUNTY	3	WAYNE COUNTY	7
DUNKLIN COUNTY	7	NODAWAY COUNTY	1	WEBSTER COUNTY	8
FRANKLIN COUNTY	6	OREGON COUNTY	2	WORTH COUNTY	1
GASCONADE COUNTY	2	OSAGE COUNTY	1	WRIGHT COUNTY	2
GENTRY COUNTY	1	OZARK COUNTY	3		
GREENE COUNTY	16	PEMISCOT COUNTY	6		

For ADULTS:

1. **Does your site offer:**

Mental Health Treatment	*10.1%*
Substance Use Disorder Treatment	*13.3%*
Both equally	*7.8%*
Both, but mental health is primary	*30.3%*
Both, but substance use is primary	*24.8%*

2. **Do you have clinicians who are <u>certified</u> in trauma-informed services?**

Yes	62.8%
No	28.9%

3. **What trauma programming or curriculum(s) are used by clinical staff at your site? (check all that apply)**

Acceptance Commitment Therapy (ACT)	*n = 28*
Cognitive Processing Therapy (CPT)	*n = 43*
Dialectical Behavioral Therapy (DBT)	*n = 75*
Exposure Therapy	*n = 17*
Eye Movement Desensitization Reprocessing (EMDR)	*n = 101*
Motivational Interviewing (MI)	*n = 169*
Seeking Safety	*n = 51*
The Sanctuary Model	*n = 2*
Trauma Recovery Empowerment Model	*n = 17*
Moral Reconation Therapy	*n = 44*
Other (please specify)	*n = 13*

- *Applied Behavioral Analysis*
- *Biofeedback*
- *RODBT*
- *TFCBT x5*
- *CBT x2*
- *Solution focused*
- *Helping Women Recover*
- *CPP x2*
- *Play therapy*

4. **What services does your site offer via tele-health?**

(n = 218)

	YES	**NO**	**MISSING**
Assessment and/or triage	*84.9% (n=185)*	*5.5% (n=12)*	*9.6% (n=21)*
Peer support	*67.4% (n=147)*	*19.3% (n=42)*	*13.3% (n=29)*
Community Support	*80.3% (n=175)*	*9.2% (n=20)*	*10.6% (n=23)*
Therapy/Counseling	*86.2% (n=188)*	*5.0% (n=11)*	*8.7% (n=19)*

Medication services *70.2% (n=153)* *18.3% (n=40)* *11.5% (n=25)*

5. **Does your site offer employment assistance to consumers outside of typical community support services or specialized programs? i.e an Employment Specialist**

(n = 218)

Yes: 59 *27.1%*
No: 142 *65.1%*
Missing: 17 *7.8%*

6. **Does your site offer specialized support with locating housing for consumers outside of typical community support services or specialized programs? i.e a Housing Specialist**

(n = 218)

Yes: 45 *20.6%*
No: 154 *70.6%*
Missing: 19 *8.7%*

7. **What telehealth/virtual platforms are used to keep clients engaged and in treatment?**

(n = 218)

	YES	NO	Missing		YES	NO	Missing
VSee	15.1% (33)	38.5% (84)	46.3% (101)	Cisco WebEx	3.2% (7)	43.6% (95)	53.2% (116)
OneDocWay	8.3% (18)	39.0% (85)	52.8% (115)	Updox	4.6% (1)	44.0% (96)	55.5% (121)
Doxy.me	38.1% (83)	29.8% (65)	32.1% (70)	Google Hangouts	13.8% (30)	38.5% (84)	47.7% (104)
SimplePractice	0% (0)	45.0% (98)	55.0% (120)	Amazon Chime	4.6% (1)	44.0% (96)	55.5% (121)
Thera-LINK	0% (0)	43.6% (95)	56.4% (123)	GoToMeeting	10.1% (22)	41.7% (91)	48.2% (105)
Zoom for Healthcare	61.5% (134)	9.2% (20)	29.4% (64)	Spruce	0% (0)	44.5% (97)	55.5% (121)
WeCounsel	4.6% (1)	44.0% (96)	55.5% (121)	OhMD	0% (0)	44.5% (97)	45.4% (99)
VTConnect	4.6% (1)	44.5% (97)	55.0% (120)	Facetime	21.6% (47)	33.0% (72)	45.4% (99)
Skype for Business	14.7% (32)	38.1% (83)	47.2% (103)	Other (Specify)	29.4% (64)	17.0% (37)	53.7% (117)

Microsoft Teams	31.2% (68)	30.3% (66)	38.5% (84)	Blue Jeans	2		
				DUO	5		
				GoogleMeet	19		
				MEND	1		
				My Chart	1		
				Otto	1		
				Phone	4		
				Polycom	8		
				Teledoc	4		
				Textabout	1		
				TrueMobile	22		

8. **What common <u>clinical</u> staff vacancies do you experience? Please rank each of the positions below in terms of FREQUENCY of vacancies on the following scale: 1- rare vacancy 2- a few vacancies per year 3- routine vacancies**

Peer Support Specialist • *Routine vacancies **27.5%*** • *A few vacancies per year **24.3%*** • *Rare to have vacancies **39.0%*** • *Missing data **9.2%***	**SUD Counselors** • *Routine vacancies **13.8%*** • *A few vacancies per year **37.6%*** • *Rare to have vacancies **37.6%*** • *Missing data **11.0%***
Community Support Specialist • *Routine vacancies **29.8%*** • *A few vacancies per year **32.6%*** • *Rare to have vacancies **30.3%*** • *Missing data **7.3%***	**Mediation Prescribers** • *Routine vacancies **5.0%*** • *A few vacancies per year **31.2%*** • *Rare to have vacancies **51.4%*** • *Missing data **12.4%***
Mental Health Therapist • *Routine vacancies **32.6%*** • *A few vacancies per year **32.6%*** • *Rare to have vacancies **28.4%*** • *Missing data **6.4%***	**Other** Providers also indicated vacancies for nursing, tech, and admin positions

9. **Does your site offer Peer Support?**

(n = 218)

Yes, part-time: 55	*25.2%*
Yes, full-time: 123	*56.4%*
No: 32	*14.7%*

Missing: 8 *3.7%*

10. **On average, how long does a *full-time* Peer Support or Community Support vacancy take to fill (from time of vacancy to start date of new hire)?**

    Peer Support or Community Support (n = 173)

    - *Less than 2 weeks* ***1.2%***
    - *2-4 weeks* ***24.9%***
    - *5-6 weeks* ***30.6%***
    - *Over 6 months* ***43.4%***

11. **On average, how long does a *full-time* mental health counselor or other clinical Master's level vacancy take to fill (from time of vacancy to start date of new hire)?**

    Clinical Mental Health Counselor (n = 187)

    - *Less than 2 weeks* ***0.5%***
    - *2-4 weeks* ***9.1%***
    - *5-8 weeks* ***20.3%***
    - *9 weeks to 6 months* ***58.3%***
    - *Over 6 months* ***11.8%***

12. **On average, how long does a *full-time* Substance Use counselor vacancy take to** fill **(from time of vacancy to start date of new hire)?**

    SUD Counselor (n = 156)

    - *Less than 2 weeks* ***2.7%***
    - *2-4 weeks* ***21.2%***
    - *5-8 weeks* ***35.9%***
    - *9 weeks to 6 months* ***32.1%***
    - *Over 6 months* ***8.3%***

13. **On average, how long does an in-person or hybrid (in-person and telehealth) medication prescriber vacancy take to fill (from time of vacancy to start date of new hire)?**

    Medication Prescriber (in-person/hybrid, n = 210)

    - *Less than 2 weeks* ***1.9%***
    - *2-4 weeks* ***1.0%***
    - *5-8 weeks* ***11.0%***
    - *9 weeks to 6 months* ***38.1%***
    - *Over 6 months* ***12.4%***
    - *Not applicable* ***35.7%***

14. **For medication prescribers who provide services solely via telehealth: On average, how long does a telehealth prescriber vacancy take to fill (from time of vacancy to start date of new hire)?**

Medication Prescriber (telehealth only, n = 120)

- *Less than 2 weeks* ***5.8%***
- *2-4 weeks* ***5.0%***
- *5-8 weeks* ***37.5%***
- *9 weeks to 6 months* ***45.0%***
- *Over 6 months* ***6.7%***

15. **What is the average tenure at your site for each of the *full-time* positions below:**

Peer Support Specialist (n = 170)

- *Less than 1 year* ***19.4%***
- *1-3 years* ***70.0%***
- *4-6 years* ***8.8%***
- *7-10 years* ***1.8%***

Community Support Specialist (n = 182)

- *Less than 1 year* ***4.9%***
- *1-3 years* ***75.3%***
- *4-6 years* ***14.8%***
- *7-10 years* ***4.9%***

Mental Health clinicians (LPC, LCSW, QMHP, n = 186)

- *Less than 1 year* ***1.1%***
- *1-3 years* ***41.4%***
- *4-6 years* ***49.5%***
- *7-10 years* ***8.1%***

Substance Use Counselors (n = 140)

- *Less than 1 year* ***5.0%***
- *1-3 years* ***57.1%***
- *4-6 years* ***32.9%***
- *7-10 years* ***5.0%***

Medication prescriber (n = 153)

- *Less than 1 year* ***2.6%***

- *1-3 years* ***50.3%***
- *4-6 years* ***39.9%***
- *7-10 years* ***7.2%***

16. **Currently, what clinical staff represent your greatest need? Rank from 1- least amount of need, to 5- most needed**

Peer Support Specialist • Least needed (1) **11.9%** • 2 **17.6%** • 3 **25.9%** • 4 **22.3%** • Most needed (5) **22.3%**	**Substance Use Counselors** • Least needed (1) **12.4%** • 2 **31.1%** • 3 **19.7%** • 4 **26.4%** • Most needed (5) **10.4%**
Community Support Specialist • Least needed (1) **11.4%** • 2 **26.9%** • 3 **19.7%** • 4 **21.8%** • Most needed (5) **20.2%**	**Medication Prescriber** • Least needed (1) **23.3%** • 2 **9.3%** • 3 **25.4%** • 4 **11.9%** • Most needed (5) **30.1%**
Mental Health clinicians (LPC, LCSW, QMHP) • Least needed (1) **40.9%** • 2 **15.0%** • 3 **9.3%** • 4 **17.6%** • Most needed (5) **17.1%**	

17. What methods are used for clinical staff recruitment efforts? Check all that apply

Method		**Number of agencies**
Social media	Facebook	166
	Twitter	70
	LinkedIn	128
	Other (specify)	Instagram x67 Indeed x 4 Network Partners Website
Newspaper		99
Television (commercials)		32
Billboard		28

Websites for job seekers (Indeed, Monster, Snagajob etc)	189
Partnership with colleges and universities	156
Employee referral program	154
Open interviews	83
Job Fair	152
Other, Please specify	62
Mailers	25
Company website	2
Recruiter	2
Internal post	1
Federal and state loan replacement program	24
Network provider	1
Nonprofit connect	2

18. **How often does your site provide support for clinical staff to attend or participate in professional development activities off-site? For example, paid registration fees for an outside professional conference.**

(n=236)

Never: 1 *0.4%*
Rarely: 15 *6.4%*
Occasionally: 65 *27.5%*
Often: 60 *25.4%*
Routinely: 65 *27.5%*
Missing: 30 *12.7%*

19. **How often does your site provide support for clinical staff to attend or participate in professional development activities on-site?**

(n=236)

Never: 1 *0.4%*
Rarely: 3 *1.3%*
Occasionally: 17 *7.2%*
Often: 87 *36.9%*
Routinely: 101 *42.8%*
Missing: 27 *11.4%*

20. **What incentives are offered to clinical staff to promote longevity/retention? (Check all that apply)**

Incentive	Number of agencies
Tuition assistance	99
Paid training/conference attendance	176
Childcare	1 (during COVID only)
Compensation incentives (raises or bonuses)	183
Recognition incentives (non-monetary awards and honors)	137
Ample opportunity for promotion	104
Opportunities to participate in specialized programs or projects	90
Flexible work schedule	162
Credentialing upgrade or renewal fee payment, or registration of licensure fee	155
Other, Please specify	
Additional time off	1
Annual training allotment	1
Clinical supervision	3
Holiday bonus and yearly anniversary bonus	1
Loan forgiveness (HRSA, NHSC)	26
Yearly PTO increases	1

21. Is clinical supervision available for staff working toward licensure (LCSW, LPC)

(n = 218)

Yes: 194 *89.0%*
No: 5 *2.3%*
Only under special circumstances: 10 *4.6%*

Please specify

- *LPC only*
- *NA to Autism programs*
- *Have multiple locations so have to pull from multiple locations to find someone to provide supervision*
- *When available x2*
- *When appropriate x4*

Missing: 9 *4.1%*

22. What are the typical <u>starting salaries</u> for the following *full-time* positions at your site?

(n = 218)

Peer Support Specialist

- *Less than $25,000: 39* *17.9%*
- *$25,000-30,000: 126* *57.8%*
- *$30,001-40,000: 29* *13.3%*
- *Over $40,000: 1* *0.5%*
- *Missing: 23* *10.6%*

Community Support Specialist

- *Less than $25,000: 0* *0.0%*
- *$25,000-30,000: 44* *20.2%*
- *$30,001-40,000: 154* *70.6%*
- *Over $40,000: 1* *0.5%*
- *Missing: 19* *8.7%*

Mental Health clinician (LPC, LCSW, QMHP)

- *$30,001-$40,000: 21* *9.6%*
- *$40,001-45,000: 51* *23.4%*
- *$45,001-50,000: 32* *14.7%*
- *$50,001-55,000: 20* *9.2%*
- *Over $55,000: 80* *36.7%*
- *Missing: 14* *6.4%*

Substance Use Counselor

- *Less than $25,000: 1* *0.5%*
- *$25,000-30,000: 9* *4.1%*
- *$30,001-40,000: 116* *53.2%*
- *$40,001-45,000: 28* *12.8%*
- *$45,001-50,000: 6* *2.8%*
- *$50,001-55,000: 29* *13.3%*
- *Missing: 29* *13.3%*

23. What are the current <u>average salaries</u> for the following *full-time* positions at your site?

(n = 218)

Peer Support Specialist

- *Less than $25,000: 26* *11.9%*
- *$25,000-30,000: 99* *45.4%*
- *$30,001-40,000: 56* *25.7%*
- *Over $40,000: 1* *0.5%*
- *Missing: 36* *16.5%*

Community Support Specialist

- *Less than $25,000: 1* *0.5%*

- *$25,000-30,000: 34* *15.6%*
- *$30,001-40,000: 142* *65.1%*
- *$40,001-45,000: 19* *8.7%*
- *$45,001-50,000: 2* 0.9%
- *Missing: 20* *9.2%*

Mental Health clinician (LPC, LCSW, QMHP)

- *$30,001-$40,000: 12* *5.5%*
- *$40,001-45,000: 38* *17.4%*
- *$45,001-50,000: 37* *17.0%*
- *$50,001-55,000: 26* *11.9%*
- *Over $55,000: 88* *40.4%*
- *Missing: 17* *7.8%*

Substance Use Counselor

- *Less than $25,000: 1* *0.5%*
- *$25,000-30,000: 7* *3.2%*
- *$30,001-40,000: 69* *31.7%*
- *$40,001-45,000: 45* *20.6%*
- *$45,001-50,000: 33* *15.1%*
- *$50,001-55,000: 27* *12.4%*
- *Over $55,000: 4* *1.8%*
- *Missing: 32* *14.7%*

24. Do you feel that your site offers a competitive wage considering the job expectations and workload for each of the following:

(n = 218)

Peer Support

- *No: 48* *22.0%*
- *Yes: 155* *71.1%*
- *Missing: 15* *6.9%*

Community Support

- *No: 54* *24.8%*
- *Yes: 151* *69.3%*
- *Missing: 13* *6.0%*

Mental Health clinician

- *No: 41* *18.8%*
- *Yes: 164* *75.2%*
- *Missing: 13* *6.0%*

Substance Use Counselor

- *No: 33 15.1%*
- *Yes: 168 77.1%*
- *Missing: 17 7.8%*

25. What is a the average caseload size (the number of actively enrolled consumers assigned) for the following:

Peer Specialist (n=236) • 0-5: 14 • 6-10: 13 • 11-15: 16 • 16-20: 36 • Over 20: 120 (About 50%) • No response: 37	**Substance Use Counselor (n=236)** • Less than 10: 13 • 11-20: 7 • 21-30: 10 • 31-40: 59 • 41-50: 72 (About 30%) • Over 50: 34 • No Response: 41
Community Support Specialist (n=236) • Less than 10: 11 • 11-20: 24 • 21-30: 100 (About 42%) • 31-40: 27 • 41-50: 24 • Over 50: 15 • No Response: 35	**Medication Prescriber (n=236)** • 1-100: 56 (About 24%) • 101-200: 32 • 201-300: 29 • 301-400: 15 • 401-500: 36 • Over 500: 27 • No Response: 41
Mental Health Clinician (n=236) • Less than 10: 9 • 11-20: 16 • 21-30: 17 • 31-40: 31 • Over 40: 131 (About 55%) • No Response: 32	

26. What are the top 3 reasons clinical staff say they leave your agency? choose 3 and rank 1(most common) 3(least common).

4.9% Pursuing educational opportunities

8.4% Career advancement

37.4% Financial Reasons

0.5% Lack of opportunities for growth or development

0.5% Feeling under-challenged

13.3% Concerns with management or coworkers

20.7% Workload issues

0.5% Feeling undervalued or unsupported

0.5% Lack of training

2.0% Work-life balance

8.9% Transfer to another agency site

1.5% Burnout

PT II Adult Consumer Access to Services

27. Are you able to serve uninsured clients?

(n = 218)

Yes: 199 *91.3%*
No: 9 *4.1%*
Missing: 10 *4.6%*

28. For uninsured clients, is a sliding scale fee used?

(n = 218)

Yes: 183 *83.9%*
No: 15 *6.9%*
Missing: 20 *9.2%*

29. If services are provided to the uninsured and no fee for service is charged, how are those services funded?

	Frequency
POS	1
A combination of public and private funding	1
Block Grant , SOR	1
Block Grants State funded	1
by county funds or through grant initiatives	1
Contract allocations	1
County Levy Funds Sometimes grants	1

	County Mill Levy	1
	County Tax Levy	1
	CPR grant	1
	CSTAR funding	1
	CSTAR grant, SOR grant	1
	Deparmental Health grants Treatment Court	1
	Department of Behavioral Health sliding scale for CSTAR services. Local County Funding for some treatment and court services. SAMHSA grant for State Opioid Response Assist clients in collaborating through pharmaceutical companies and pharmacies for samples prn SATOP provides a strong sliding scale but has minimum payments.	1
	department of mental health	1
	Department of Mental Health contracted services	1
	Department of Mental Health Grants Pro bono Treatment Court funding	1
	Department of Mental Health service contracts	1
	Department of Mental Health, grants	1
	department of mental health, grants,	1
	Department of Mental Health, Grants, Pro Bono	1
	Department of Mental Health, Grants, Pro Bono, Treatment Court	1
	Department of Mental Health, Grants, Pro Bono, Treatment Court, etc...	1
	Department of Mental Health, Treatment Court, Grants & Pro Bono	1
	Department of Mental Health; grants; pro bono	1
	Dept Mental Health grants, treatment court funding	1
	DMH	16
	DMH funding based on diagnoses.	1
	DMH funds for uninsured SUD clients.	1
	DMH grants and free services	1
	DMH pilot/grant	1
	DMH, grants	1
	DMH, Grants, Etc	1
	DMH, pro bono, grant funding	1
	DMH, pro-bon, grants, and OSCA funds for treatment court clients.	1
	for some we are able to utilize funds through a Rapid Enrollment agency grant	1
	FQHC	1
	General Revenue Funds	1
	General Revenue non-Medicaid funding	2
	Grant funding (e.g. United Way, Health Forward Foundation), internal fundraising initiatives.	1
	Grant funding for clients who are enrolled in CPRC; otherwise for outpatient therapy and psychiatry, client's are only eligible for grant funded services if enrolled CPRC	1
	Grant funding for CPRC services; client's are unable to access outpatient servies for no fee unless under grant funded CPRC services	1
	Grant funds and donations	1
	grant or county tax funds	1
	Grant, DMH, pro-bono	1
	Grants	29
	Grants and other funding sources	1
	Grants or state funding	1
	Grants, (e.g. United way), Internal fundraising initiatives	1

	grants, county funds	1
	Grants, DMH Funding	1
	Grants, pro bono.	1
	Grants,Department of Mental Health,Pro bono	1
	MOSAT grant, Scholarships,	1
	non-Medicaid dollars or charity care	1
	Our uninsured and no fee services are charged to our state contracts.	1
	POS dollars allocated by DMH	3
	POS funds covers some of the costs	5
	Rapid enrollment grant	1
	Some DMH funds are available for uninsured clients but not enough to cover the need.	18
	Some fund raising and grants	1
	SOR Block Grant	1
	State/Federal funding	1
	Tax based funding, DMH, grants and pro-bono	1
	The state will pick up the charges as long as the client is below the level on the sliding scale.	1
	The Urgent Behavioral Solutions was a SAMHSA 2 year grant	1
	There are a couple of grants that an uninsured client can be placed on to help ease their financial burden.	1
	Through grants, general revenue funds, and other fund sources	1
	Through Rapid Enrollment grant	1
	Through the daily rate and grant funding	1
	Uncompensated care is offered through our cash reserves.	1
	various- grants, miltax,	1
	We absorb the cost	1
	We charge a minimal amount per session.	1
	We have access to county funding for mental health and for substance use treatment.	1
	We have some grants that assist	1
	WE PROVIDE A NOMINAL FEE FOR SERVICE	11
	We utilize grant funding, such as United Way, General Revenue funding, etc.	1
	With either a FQHC grant, DMH non-Medicaid funds, or agency resources	1

30. Do you have a physical location for adult outpatient services in each county of your site's catchment area?

(n = 218)

Yes: 129 *59.2%*
No: 79 *36.2%*
Missing: 10 *4.6%*

31. Does your site offer transportation to the treatment office if a consumer resides out of county?

(n = 218)

Yes: 20 *9.2%*
No: 21 *9.6%*

Only in special circumstances: 37 *17.0%*

- *Individual need*
- *Staff availability x4*
- *Depends on options for local transport x2*
- *If need on treatment plan x21*
- *No other options x2*
- *Sometimes CS assists*

Missing: 140 *64.2%*

32. What modes of transportation are available to consumers needing to travel to another county within your catchment area to receive outpatient services? Check all that apply

Transportation	Frequency
Taxi, Uber, Lyft, or other ride-share	**110**
Public transit (city bus, OATS)	**136**
Non-Emergency Medical Transportation (LogistiCare, Abilitrans, etc)	**101**
Other, please specify	
Agency Staff	**31**
CSTAR	**1**
Natural Supports	**1**
Oats	**1**

33. If necessary, does your site assist consumers with paying for transportation needs to the treatment location? (taxi vouchers, bus passes, etc)-

(n = 218)

Yes: 91 *41.7%*

No: 62 *28.4%*

Only in special circumstances: 54 *24.8%*

- *Bus pass only*
- *Crisis x3*
- *Determined by acuity x2*
- *If approved*
- *If NEMT is not available x2*
- *Limited eligibility funding x21*
- *No other options*
- *Taxi voucher occasionally*
- *Program specific x11*
- *Rural*
- *SOR detox*
- *Specific grant funding will pay*

- *Staff sometimes*
- *Through ERE program*
- *Offer gas cards*

Missing: 11 5.0%

34. **If your site provides residential or inpatient substance use disorder treatment, what is the current admission wait time for eligible new patients that are NOT considered a priority population? *Priority populations may include pregnant women and new mothers, Persons Who Inject Drugs (PWID), high risk offenders referred by the Department of Corrections, recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, or other populations designated as a priority by the Department of Mental Health***

Residential or inpatient substance use disorder treatment: (n=200)

24 hours or less	2.5%
1-5 business days	5.5%
6-10 business days	2.0%
11+ business days	13.5%
Do not offer	76.5%

35. **Do you routinely have a wait list for residential/inpatient treatment?**

(n = 218)

Yes: 45	20.6%
No: 62	28.4%
Missing: 111	50.9%

36. **If your site provides social setting detox services, what is the current admission wait time for eligible new patients who are NOT considered a priority population? *Priority populations may include pregnant women and new mothers, Persons Who Inject Drugs (PWID), high risk offenders referred by the Department of Corrections, recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, or other populations designated as a priority by the Department of Mental Health***

***Social setting detox* (n=196)**

24 hours or less	7.7%
1-5 business days	3.1%
6-10 business days	0.5%
11+ business days	2.6%
Do not offer detox	86.2%

37. **If your site provides Medically Monitored Inpatient Detox (MMID) services, what is the current admission wait time for eligible new patients who are NOT considered a priority population? *Priority populations may include pregnant women and new mothers, Persons Who Inject Drugs (PWID), high risk offenders referred by**

the Department of Corrections, recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, or other populations designated as a priority by the Department of Mental Health*

Medically Monitored Inpatient Detox (MMID): (n=192)

24 hours or less 4.7%
1-5 business days 2.1%
11+ business days 1.0%
Do not offer MMID 92.2%

38. **For eligible new <u>outpatient</u> clients NOT considered a priority population, what is the current wait time for the following services? *Priority populations may include pregnant women and new mothers, Persons Who Inject Drugs (PWID), high risk offenders referred by the Department of Corrections, recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, or other populations designated as a priority by the Department of Mental Health***

Intake assessment/triage (n = 204)
24 hrs or less 27.5%
1-5 bus. days 27.0%
6-10 bus. days 33.8%
11+ bus. days 11.8%

Community support (n = 200)
Less than one week 58.5%
1-3 weeks 31.0%
4+ weeks 10.5%

Mental health counseling (n = 199)
Less than one week 34.2%
1-3 weeks 37.2%
4-6 weeks 17.6%
More than 6 weeks 11.1%

Substance use counseling (n = 198)
Less than one week 45.5%
1-3 weeks 41.4%
4-6 weeks 5.1%
More than 6 weeks 8.1%

Medication services (MAT, psychiatry) (n = 199)
Less than one week 37.7%
1-3 weeks 46.2%
4-6 weeks 8.5%
More than 6 weeks 7.5%

Therapy groups/psycho-social rehab (n = 200)

Less than one week 49.0%

1-3 weeks 39.5%

4+ weeks 11.5%

39. For what outpatient services do you have a wait-list (check all that apply)?

	Agencies
Intake/assessment/triage	66
Community Support	23
Mental health counseling	35
Substance Use counseling	19
Medication services (MAT, psychiatry)	42
Groups/psychosocial rehabilitation	20

40. Do you believe that there are any gaps in services, or adult populations that are unserved or underserved at your site?

43.6% (95) reported **NO GAPS**

18.8% (41) missing

- No shows
- Affordable housing; housing options (x5)
- Ambulatory detox
- Client participation in groups while waitlisted for services (x2)
- Sliding fee services too expensive for many people, services for uninsured (x8)
- DBT services are expensive, especially for adolescents (x2)
- Community support services (x2)
- Waitlists for adult services
- SUD counseling, detox, not having these services and not getting people in fast enough (x10)
- Quick access to medications
- Not able to provide assessments at certain locations so takes longer to access services (x2)
- ER Enhancement Mental Health triage
- Employment assistance (x3)
- Groups in general (x3)
- Little staff, high caseloads, lack of licensed staff, availability of staff (x12)
- ACT-TAY (x3)
- IPS
- MAT (x9)
- Open access
- Peer support (x2)

- Primary care (x2)
- Dental services (x3)
- Psychiatry and therapy (x5)
- Transportation (x5)
- Trauma services

41. What population is unserved or underserved at your site? If none, please write "none."

		Frequency
	None	108
	80-90%	1
	Adolescent SUD, Clients on slide that cannot afford to pay for psychiatry and therapy - often can only engage in psych because they can't pay the slide on-going; homeless clients	1
	adolescent SUD, clients on slide that cannot afford to pay for services, homeless clients	1
	Children and Adults with no Medicaid, Medicare, or commercial insurance	1
	Client with substance use disorders	1
	clients needing inpatient or residential treatment	1
	Clients seeking counseling services are currently underserved.	1
	Clients with no insurance and limited finances	1
	Clients with no insurance, little to no income, can find it difficult to afford services	1
	Clients without insurance, often those that fall in the Medicaid gap, that can not afford services on a slide or self pay fee	1
	Currently, the dually diagnosed individuals, but we are working to resolve this.	1
	Due to the size of the County those without transportation are underserved in our area.	1
	Given the population breakdown in our area African-American, Hispanic, LGBTQ	1
	Hispanic is underserved, but just hired a Hispanic therapist	1
	Hispanic, African American and LGBTQ individuals are underserved.	1
	homeless	4
	Homeless, uninsured/underinsured, hispanic population	1
	I see an unserved and or under served population at our site such as Latinos in which we rarely see.	1
	Individuals in rural areas struggle to receive Autism services.	1
	LGBTQI	1
	MALE PPTS. NOT IN PP.	6
	MAT clients	3
	NARR Accredited Housing sites	1
	Need more therapists and prescribers.	1
	Non-Treatment Court SUD persons	1
	Our ICTS site serves only DOC referred clients per our contract.	1
	People without insurance	1
	Primary sub use disorders, veterans, 3rd party payers	2

	Seriously mentally illness due to lack of community support staff	1
	Spanish Speaking	1
	Substance Use	1
	Substance use disorder/MAT	1
	Substance use/co-occurring Transitional Youth Young children (ages 2-7)- limited access to training opportunities for EBPs with this population. Both due to funding and space issues for these interventions.	1
	SUD clients who are not a part of the treatment court system.	3
	SUD, co-occurring, transitional youth, young children	1
	Third party payers, Primary Substance Abuse Disorders, Veterans	2
	Those who lack transportation.	1
	Underinsured customers often have high copays, or spend-down for Medicaid, which can be prohibitive despite having insurance coverage.	1
	Underinsured people with commercial insurance and Medicaid with high spend downs	1
	Uninsured	9
	UOD consumer services not enough qualified staff to meet the need for treatment on demand	1
	we do need to add substance use counseling and increase our MAT services. Target for CCBHO	1
	we have a number of youth/ families that are Spanish speaking, etc. so I anticipate language barriers contribute to particular ethnic/cultural groups not engaging in services.	1
	We serve all adults 16 years of age and older at our Urgent Behavioral Solutions facility.	1
	While translation services are made available we have fewer non-English speaking clients now than in the past. We have ASL and local translators as well as a contracted telephone translation service available as needed.	1
	Women with addiction needs	1
	Women with children with no transportation or childcare consistently have access barriers	1

PT III- Now we would like to ask some questions specifically pertaining to services provided to the adult justice-involved population. By "justice-involved" we are referring to ADULT consumers who are on community supervision by the courts or Probation and Parole, those with pending *criminal* court matters, or those who have experienced involvement in those areas within the past 3 years.

42. At your site, how qualified do staff feel providing services to justice-involved individuals? (1-5 scale)

Staff feel on providing services to justice-involved individuals: (n=205)

A great deal **30.7%**
A lot **34.1%**
A moderate amount **30.2%**

A little **4.4%**
None at all **0.5%**

43. At intake, are consumers asked about their justice-involvement?

(n=205)

Information about current and past justice involved asked: 192	93.7%
Only information regarding CURRENT justice involvement: 9	4.4%
Not at all: 4	2.0%

44. What are the top 3 PRIMARY diagnosis presented by justice-involved consumers (please rank. 1- most common-3 least common)

Substance Use and Addictive Disorders:	**159 agencies ranked this as #1**
Schizophrenia Spectrum and Other Psychotic disorders	
Bipolar and Related Disorders	**73 agencies ranked this as #2 or 3**
Anxiety disorders	**60 agencies ranked this as #2 or 3**
Obsessive Compulsive and Related Disorders	
Trauma and Stressor-related disorders	**85 agencies ranked this as #2 or 3**
Dissociative Disorders	
Depressive Disorders	**75 agencies ranked this as #2 or 3**
Personality disorders	
Other (please specify)	

45. What are the top 3 SECONDARY diagnosis presented by justice-involved consumers (please rank. 1- most common-3 least common)

Substance Use and Addictive Disorders	**63 agencies ranked this as #1**
Schizophrenia Spectrum and Other Psychotic disorders	
Bipolar and Related Disorders	
Anxiety disorders	**90 agencies ranked this as #2 or 3**
Obsessive Compulsive and Related Disorders	
Trauma and Stressor-related disorders	**83 agencies ranked this as #1, 2, or 3**
Dissociative Disorders	
Depressive Disorders	**109 agencies ranked this as #1, 2, or 3**
Personality disorders	**54 agencies ranked this as #2 or 3**
Other (please specify)	

46. We have a responsibility to ensure justice-involved consumers are engaged in treatment and services.

(n=236)

Neither agree nor disagree: 1	*0.4%*
Somewhat agree: 22	*9.3%*

Somewhat disagree: 5 *2.1%*
Strongly agree: 176 *74.6%*
Strongly disagree: 1 *0.4%*
Missing: 31 *13.1%*

47. Our site designates *specific* staff to work with the justice-involved population.

(n = 236)

No, justice-involved clients are distributed the same as other clientele: 93 *39.4%*
Some staff tend to have more justice-involved clients than others: 84 *35.6%*
Yes, certain staff are designated to work with this population: 28 *11.9%*
Missing: 31 *13.1%*

48. To what extent do you agree with this statement: We have a responsibility to ensure justice-involved consumers are engaged in treatment and services.

(n = 218)

Strongly Agree: 176 *80.7%*
Somewhat Agree: 22 *10.1%*
Neither Agree nor Disagree: 1 *0.5%*
Somewhat Disagree: 5 *2.3%*
Strongly Disagree: 1 *0.5%*
Missing: 13 *6.0%*

49. Would clinical staff be comfortable with a *full caseload* of justice-involved consumers?

(n = 218)

Not at all: 5 *2.3%*
A few staff would be okay with this: 88 *40.4%*
Most staff would be okay: 112 *51.4%*
Missing: 13 *6.0%*

50. Please describe the level of support services and resources available for justice-involved consumers in your community. Support services are services which assist the client in overcoming barriers which, when unaddressed, can potentially lead to criminal activity, re-incarceration, and/or victimization. Support services and resources include, but are not limited to: Safe and affordable housing; employment opportunities that allow a gainful and living wage; education and vocational training opportunities; community-based activities that promote pro-social behaviors; and services necessary to develop life-skills which lead the individual toward self-sufficiency.

(n=205)

*No support **1.0%***
*Little support **22.9%***
*Some support **50.7%***
*Adequate support **18.0%***
*Abundant support **7.3%***

51. In general, clinical staff have a positive opinion of justice-involved consumers.

(n=236)

Strongly agree: 51	*21.6%*
Somewhat agree: 131	*55.5%*
Neither agree nor disagree: 20	*8.5%*
Somewhat disagree: 2	*0.8%*
Strongly disagree: 0	*0%*
Missing: 32	*13.6%*

52. How much do you agree with this statement: In general, clinical staff have a positive opinion of justice-involved consumers.

(n = 218)

Strongly agree: 51	*23.4%*
Somewhat agree: 131	*60.1%*
Neither agree nor disagree: 20	*9.2%*
Somewhat disagree: 2	*0.9%*
Strongly disagree: 0	*0%*
Missing: 14	*6.4%*

53. Describe the working relationship between your site and the local Probation and Parole office.

(n = 218)

No relationship: 2	***0.9%***
Poor relationship: 0	***0.0%***
Fair relationship: 32	***14.7%***
Good relationship: 133	***61.0%***
Excellent relationship: 38	***17.4%***
Missing: 13	*6.0%*

54. How much do you agree with this statement: Justice-involved consumers have different needs than other consumers.

(n=236)

Strongly agree: 39 *16.5%*
Somewhat agree: 133 *56.4%*
Neither agree nor disagree: 17 *7.2%*
Somewhat disagree: 14 *5.9%*
Strongly disagree: 2 *0.8%*
Missing: 31 *13.1%*

55. How much do you agree with this statement: The monetary return on investment for justice-involved consumer services is adequate for the time and resources invested in them.

(n=236)

Strongly agree: 48 *20.3*
Somewhat agree: 57 *24.2%*
Neither agree nor disagree: 45 *19.1%*
Somewhat disagree: 46 *19.5%*
Strongly disagree: 9 *3.8%*
Missing: 31 *13.1%*

Please explain why you answered in the way you did in the above question.

		Frequency
	Believe that rates overall need to be increased to support cost of providing services	1
	All clients are worth their time and effort no matter their justice-involvement.	1
	Any reduction in recidivism promotes an increased investment back into the community.	1
	Believe that rates overall need to be increased to support cost of providing services	3
	Better in treatment that in prison.	1
	Better to treat than to incarcerate.	1
	By providing supportive resources to consumers we are reducing reincarceration which reduces the overall costs associated with this.	1
	Clients can progress more staying in the community	1
	Community Based services are less expensive than correction facilities	1
	Community Based services are less expensive then placement in a correctional facility	1
	Community treatment and services will help more than sending to prison, at least deserve a chance before that	1
	Comunity Based services are less expensive than correction facilities	1
	Considering the impact on society at large any positive changes are beneficial for all of us. Interesting question. I tend to not look at the monetary return instead I tend to look at the human.	1

	Crisis services do not bill for those seen	1
	Depending on the clients needs.	1
	Depends on willingness of consumer to engage in treatment.	2
	Each person treated is worth the investment to try to help them improve their life and society as a whole	1
	Enrolling justice involved consumers takes more time due to the level of communication required with the state system.	1
	Fees for services do not always reflect the amount of effort needed for specific clients It is not a reflection on the referral source of the client.	1
	High rates of unemployment with low literacy levels and minimal job skills	1
	I am not privy to information regarding monetary return, etc., in my current position.	1
	I believe people should be giving an opportunity to be successful and for some it will require additional resources for this to happen.	1
	I believe that investment in justice-involved consumers in the community is important and would probably outweight the future costs of incarceration.	1
	I believe this population would benefit from more specialized services. Not sure what the cost would be, but agree that there would be a good return on investment for enhancing care and treatment.	1
	I do not have access to information regarding the financial investment or return on this population.	1
	I do not have specific data to clarify. Mostly DMH reimbursed services.	1
	I don't have access to information regarding this question.	1
	I feel that the monetary return is adequate for all the client's we serve.	1
	I feel we need to focus on justice-involved clients as much as we focus on insured consumers as they have higher needs	1
	I'm not sure I understand the statement: I'm not sure there is enough time and resources invested in our justice involved consumers. I do not believe that we have enough of these individuals actively referred to us from probation and parole that could benefit from our services. We have many that make it into our services on their own accord despite lack of referral/encouragement from the justice side, a more coordinated effort in supporting and encouraging their success in treatment and other supportive services would show great benefit.	1
	In most cases, when we work successfully with justice involved individuals, they increase their chances of becoming employed, support their families, pay taxes and decrease their chances of costly recidivism.	1

	In our positions, we are not aware of the monitory investment and return for this population.	1
	In terms of finances, it would be more cost effective for programs to assist these individuals in the community, rather than have them incarcerated.	1
	Incarceration is expensive in many ways.	1
	Independent, employed citizens are always a good return an investment to our communities.	1
	Independent, employed citizens are always a good return on investment to our communities.	20
	Investing in rehabilitation typically yields higher dividends than punitive measures such as incarceration- financially, socially, and ethically.	1
	Investment in treatment can pay off with less crime	1
	It takes much more time with some of the demands of the court, justice system, reports and consumer in general to treat those involved in CJ system.	1
	It's less expensive to be in treatment than in prison/jail	1
	Justice involved clients have some challenges in the community with housing due to legal issues	1
	Justice involved consumers deserve the same chance at recovery as other consumers.	1
	Many of these clients require extensive time and effort to help them maintain their recovery, mental health stability and to avoid reoffending and the reimbursement or return on those clients are the same as others. It addition these clients often require wrap around services and take advantage of everything offered (housing, employment, peer, CSS, therapy, medication, crisis management, etc.)	1
	More cost effective and better outcomes generally treating in outpatient vs. in prison	1
	More investment is needed to obtain infrastructure for their.	1
	Most often justice-involved consumers are more engaged due to legal obligations and support of probation and parole.	1
	No services should be based on monetary return. Justice-involved consumers services prevent reincarceration, reduces crime, brings families together, that is worth all the time and engergy spent with each client not just justice client	1
	OUr department of corrections have become primary treatment for many individuals that need MH or SUD services - in other words we have many individuals in prison that need to be in community based treatment servics	1
	Our ICTS program is a justice involved program. I am very aware of the research that demonstrates the amount of tax payer money saved through investment in treatment of this population.	1
	PATIENT CARE IS MORE IMPORTANT THAN MONEY.	11

	Seen clients react positively to treatment	1
	Some clients take advantage of the opportunities while others do not.	1
	Some individuals will complete treatment while others will only initiate services due to it being a probation requirement. Those that complete promote a monetary return, but those that do not increase our costs due to no shows. In a macro scale, the return on investment is worth it.	1
	Some of the services that we provide these clients are not able to be reimbursed, though investing in this population has a significant impact on a societal level.	1
	Sometimes treatment can prevent prison or return to it	1
	Staff involved in treatment courts spend a lot of time communicating with treatment court and completing required reports.	1
	That treatment is better than prison	1
	The cost of outpatient is better than the cost of prison treatment	1
	The curriculum and training to keep up with the best practices and EBP is expensive to serve this population. To achieve positive outcomes the cost for training, curriculum and the higher wages to retain staff create a need for increased payment for services.	1
	The impact of the services positively disrupts the cycle of substance abuse and crime for many of our clients	1
	The lack of funds available to pay for services for this typically non-Medicaid poplation	1
	The lack of funds available to pay for this typically non-Medicaid population.	23
	The legal involvement changes dynamics.	1
	The monetary return is not directly beneficial to my organization but I believe it is beneficial to the community as a whole.	1
	The ROI is significantly higher to pursue treatment versus punitive measures. Rehabilitation is usually the stronger investment.	1
	They require more intensive support, lack housing and job opportunities. It take more to find resources due to barriers.	1
	This population tends to have among the highest documentation and external reporting obligations, which requires additional time and effort by clinicians.	1
	This population tends to have among the highest documentation and external reporting obligations, which requires additional time and effort for clinical staff.	1

	This response warrants more of a thesis, than a general survey response. We are strapped for resources, our staff carry extremely large caseloads, we pay salaries to counselors that are marginally above the poverty line and we're still struggling to stay afloat. Justice involved consumers tend to have more extensive trauma backgrounds and psychiatric diagnoses, but our funding indicates they should get a lower quality of care than someone with mild depression who has the means to self-pay at a private practice.	1
	Treating in the community is better than punishment if they have SUD issues	1
	Treating in the community is less costly than in the institution	1
	Treatment can be an alternative to prison	1
	Treatment can work and prevent return to prison or recurrent crime	1
	varies with each person	1
	We are in a small town with limited resources for this population.	1
	We do not look at a justice-involved client as an investment. We look at them on how we can help strengthen their life and help provide current needs.	1
	We don't look at the monetary return. We look at what a client needs.	1
	We have some unbillable services involved in providing administrative support for justice-involved consumer services, especially for those not involved in a formal treatment court program with added funding resources. Travel to/from various courts is an expectation.	1
	We see a difference with those that get treatment while on probation	1
	Total	218

56. Does your site designate staff to participate on a local Treatment Court team (Drug Court, Mental Health Court, or other problem-solving court)?

(n = 218)

No participation, but Treatment Courts are available in our service area: 40 *18.3%*
Consult services only: 21 *9.6%*
Full participation: 112 *51.4%*
N/A- I am unaware of any Treatment Courts in our service area: 33 *15.1%*
Missing: 12 *5.5%*

57. Of your site's current adult population served, what percentage would you estimate is CURRENTLY justice-involved?

(n=207)

Less than 10% **23.2%**
11-25% **32.9%**
26-50% **19.8%**
Over 50% **24.2%**

58. Of your site's current adult population served, what percentage would you estimate have a HISTORY of justice-involvement?

(n=208)

Less than 10% **13.0%**
11-25% **25.5%**
26-50% **26.9%**
Over 50% **33.7%**

59. If your site provides residential or inpatient substance use disorder treatment, what is the current admission wait time for eligible new *justice-involved* patients who are NOT considered a priority population? *Priority populations may include pregnant women and new mothers, Persons Who Inject Drugs (PWID), high risk offenders referred by the Department of Corrections, recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, or other populations designated as a priority by the Department of Mental Health*

Residential or inpatient substance use disorder treatment: (n=200)

24 hrs or less **2.5%**
1-5 bus. days **6.5%**
6-10 bus. days **4.5%**
11+ bus. days **9.5%**
Don't offer this **77.0%**

60. If your local site provides social setting detox services, what is the current admission wait time for eligible new *justice-involved* patients who are NOT considered a priority population? *Priority populations may include pregnant women and new mothers, Persons Who Inject Drugs (PWID), high risk offenders referred by the Department of Corrections, recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, or other populations designated as a priority by the Department of Mental Health*

Social Setting detox: (n=199)

24 hrs or less **8.5%**
1-5 bus. days **3.5%**

6-10 bus. days **1.0%**
11+ bus. days **2.0%**
Don't offer this **84.9%**

61. **If your local site provides Medically Monitored Inpatient Detox (MMID) services, what is the current admission wait time for eligible new *justice-involved* patients who are NOT considered a priority population? *Priority populations may include pregnant women and new mothers, Persons Who Inject Drugs (PWID), high risk offenders referred by the Department of Corrections, recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, or other populations designated as a priority by the Department of Mental Health***

Medically Monitored Inpatient Detox (MMID): (n=199)

24 hrs or less **4.0%**
1-5 bus. days **2.0%**
6-10 bus. days **0.5%**
11+ bus. days **0.5%**
Don't offer this **93.0%**

62. **Is there routinely a wait-list for justice-involved consumers to receive outpatient services?**

(n = 218)

Yes: 41 *18.8%*
No: 162 *74.3%*
Missing: 15 *6.9%*

63. **What in-house training does your site offer to clinical staff regarding treatment of justice-involved consumers?**

	Frequency
	58
1:1 training and online learnings	1
All therapy staff are trained in CBT and other evidenced based therapy protocols	1
Annual conference	1
As an exclusive provider to justice involved consumers, Gateway has a full training plan for each staff, some that are general and others that are specific to their job duties.	1
At present, we are training with other SUD staff in our Southwest area, as we do not have a CSTAR contract in this region.	1
Clinical management of these consumers is the same and we provide annual clinical trainings as well as clinical trainings during the onboarding/new hire process.	1
Clinical management of these customers is the same. We provide annual clinical training as well as onboarding.	1
collaboration with P&P	1

	COLLABORATION WITH PROBATION AND PAROLE, TYPICALLY SEND CLINICAL STAFF TO OUTSIDE MRT TRAININGS	1
	company wide annual training	1
	Consistent training with the trends of the moment	1
	Crisis intervention training, motivational interviewing, resource management, interviewing techniques, safety planning and de-escalation.	1
	Degree program, Relias, and in house trainings are offered to address justice-involvement treatment	1
	Entry supports	1
	Evidence based practices trained in are also applicable to justice involved consumers (ex: CBT, MI, trauma protocols)	1
	If working with TX courts, there is training specific to that.	1
	Included as part of orientation for clinicians	1
	Inservice and online training	1
	Limited	22
	Many staff are MRT certified, some are HEAT certifies, and there is significant collaboration with local Probation and Parole offices for training and other collaboration efforts.	1
	MI & person centered trainings offered regularly, supervisor is trained in MRT and provides additional and ongoing training to staff providing these services. Site also coordinates with courts to provide training to staff on treatment court processes.	1
	MI, MyStrength, Trauma	1
	MI, MyStrength, trauma, MRT	1
	Motivation Interviewing, other clinical thinking error trainings	1
	MOTIVATIONAL INTERVIEWING AND TRAUMA INFORMED CARE.	11
	Motivational Interviewing, Contingency Management, Peaceful Intervention, HEAT	1
	Motivational Interviewing, Person Centered, general Substance Use training, and online relias training.	1
	MRT	1
	MRT treatment, MI	1
	MRT, trauma related training	1
	MyStrength, MI	1
	No currently in-house training, but community training with the treatment courts	1
	On going training.	1
	On going treatment court training, ongoing monthly staffings with P&P	1
	Ongoing through MCB and Relias E-learning.	1
	Online and in-person trainings regarding clinical considerations for working with this population.	1
	Our primary referral resource if probation and parole so all of our training is geared towards justice involve clients	1
	Our site utilizes relias for in house virtual training. Other forms of trainings offered include MRT, and Motivational Interviewing.	1
	Our training is typically offsite due to program size.	1
	Personnel who are involved receive state training when it is offerred	1
	Re entry support staffing with P&P MRT	1
	Re-entry programs & staffing	1
	Re-Entry Supports, Collaboration with P&P/DOC, Staffing w/P&P, Authorization to Release Information, Communication with P&P	1

	Relias	1
	Relias for MI, trauma, inservice on MyStrength	1
	Relias Learning course - Managing Offender Resistance	10
	Relias Learning courses - Managing Offender Resistance	2
	Relias Learning courses - Managing Offender Resistance and Understanding Addiction: An Overview for Corrections Professionals	12
	Relias training on topics related to thinking errors.	1
	Relias trainings and various webinars	1
	Relias trainings, webinars, seminars and conferences	1
	Relias, consultation, most staff have received training either through organization or through degree program. Typically both.	1
	Reporting to probation and parole, Community Treatment and Referral Services with DOC, Treatment Court expectations and reporting, Trauma training.	1
	Semi-annual in-service training is offered by a supervisor.	1
	Some staff have an online module required at orientation and every couple of years.	1
	specific training related to COD; DMH supported trainings and other tx offered in STL area with partners.	1
	Staff are trained on HIPAA and 42 CFR and the criminal justice services authorization form. Staff are trained on when to contact P&P	1
	staffing P and P, rules that apply to justice involved individuals, re-entry services.	1
	Staffing with POs	1
	staffing with probation & parole officers	1
	SUD treatment training.	1
	SUD treatment trainings	1
	Trained in evidenced based practices that could also be used with justice involved consumers	1
	Trained in evidenced based therapy protocols such as CBT, DBT, EMDR, etc.	1
	Training on disclosures to law enforcement	1
	Trauma and MI	2
	Trauma, MI, and other clinical thinking error training on Relias	1
	Trauma, MI, MRT, MyStrength	1
	Trauma, MI, MyStrength	1
	Trauma, MyStrength Motivational Interviewing	1
	Trauma, MyStrength, MI	1
	Typically as needed. Most of our justice-involved training is handled through clinical supervision from Clinical Director, through our other programs that work primarily with justice-involved, and through various Relias trainings.	1
	Use of Moral Reconation Therapy to address support	1
	various relias trainings	3
	Virtual (Relias) and in-service training is provided regularly by SUD clinical leadership/corporate trainers on Motivational Interviewing, ASAM levels, urine drug screen collection, reporting progress to referral sources (P&P), and other topics relevant to this population.	1
	Virtual (Relias) and in-service trainings by SUD clinical leadership & corporate trainers on MI, ASAM levels, urine drug screen collection, and other topics relevant to population	1

	We do team building meetings between OP and treatment courts. Also there have been trainings between Probation and Parole and OP	1
	WE offer in services and staff have been sent to gain MRT training.	1
	We train on individualized treatment on a regular bases. We staff monthly with our local Probation and Parole.	1
	We train staff in the Matrix Criminal Justice model.	1
	Webinars and any outside training that may be available	1
	Weekly clinical supervision and case presentation studies.	1
	Yes, Annual training by the courts	1
	Total	218

64. How would you rate your clinical staff's familiarity with the Probation and Parole client assessment process, the Ohio Risk Assessment System (ORAS)?

(n=236)

A great deal: 9	*3.8%*
A lot: 10	*4.2%*
A moderate amount: 55	*23.3%*
A little: 61	*25.8%*
None at all: 69	*29.2%*
Missing: 32	*13.6%*

65. For consumers on probation or parole supervision, what collaboration is done between your site and the Probation or Parole Officer when developing treatment and case plans?

(n = 218)

No collaboration with the Probation or Parole Officer: 2	*0.9%*
We don't collaborate, but provide them a copy (if the consumer consents): 19	*8.7%*
Occasional, limited, or only collateral collaboration: 105	*48.2%*
Strong collaboration and input from the Officer: 78	*35.8%*
Missing: 14	*6.4%*

66. What evidenced-based strategies, programming and interventions being used by Probation and Parole is your clinical staff familiar with? Check all that apply

Strategy	Frequency
We are not familiar with any evidenced based programming or interventions used by Probation and Parole	74
Decision Points	1
Pathway to Change	57

Moving On	1
Moral Reconation Therapy (MRT)	79
Carey Guides	0
Brief Intervention Tools (BITS)	6
Missouri Offender Management Matrix (MOMM)	13
Other, specify	
HEAT	2
Matrix	2

67. Aside from your Community Mental Health Liaison (if applicable), does your site provide any in-person service to a consumer incarcerated in a local jail (outreach, treatment, community support, etc)

(n = 218)

No, we are unable to provide any service to someone who is incarcerated in the local jail: 132	60.6%
Yes, for existing consumers only, but we cannot bill for the service: 27	12.4%
Yes, for existing consumers only, and we are able to bill for the service: 17	7.8%
Yes, we are able to see inmates of the local jail, regardless of whether or not they are an existing consumer at our agency, but we cannot bill for the service: 19	8.7%
Yes, we are able to see inmates of the local jail, regardless of whether or not they are an existing consumer at our agency, and we can bill for the service: 8	3.7%

68. What services can be provided to an established consumer of your agency while they are in the jail?

Service	**Frequency**
Community Support	38
Outreach	24
Clinical services	32
Medication services	28
Other (please specify)	
Assessment	1
Crisis	19
Coordination of care	1
Medication refills	1

69. What services can be provided to an inmate of a jail who is not already established with your agency?

Service	Frequency
Community Support	2
Outreach	30
Clinical services	5
Medication services	5
Other (please specify)	
Assessment	2
Crisis	20
CMHL	1
Screening	1

70. In your site's catchment area, do you feel that more Community Mental Health Liaisons (and/or Substance Use Disorder Liaisons) are needed to adequately manage the number of referrals received and the size of the territory covered?

(n = 218)

Yes, more CMHL's and SUDL's are needed: 168 *77.1%*
Only more CMHL's are needed: 11 *5.0%*
Only more SUDL's are needed: 7 *3.2%*
No, we have an appropriate number of CMHL/SUDLs: 17 *7.8%*